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THE BRITISH JOURNAL OF DERMATOLOGY

CONTENTS.

PAGE

On a Form of Chronic Superficial Dermatitis in Circumscribed Patches with Symmetrical Distribution occurring in Children. H. G. ADAMSON, M.D.Lond., M.R.C.P. . . 109

The Sixth International Dermatological Congress at New York in September, 1907 123

Royal Society of Medicine—Dermatological Section.—Pustular ringworm of the horse ("conglomerate folliculitis") in a child.—Urticaria pigmentosa.—Favus. — Ringed eruption. — Bilateral telangiectases. — Case for diagnosis.—Acute scarlatiniform eruption following the administration of small doses of quinine.—Sections of a hard Hunterian chancre.—Film-preparation.—Bromide eruption.—The effect of X-rays on Mycosis fungoides.—Lupus, with unusual features, suggesting Lupus pernio.—Chronic X-ray dermatitis of the hands; removal of warts by measured doses of the X-rays . . . 126

Editoral—Sir Malcolm Morris, K.C.V.O. 142

Current Literature—The histology of the depressed white spots in universal erythrodermias.—A case of "Acne necrotisans et exulcerans serpiginosa nasi" of Kaposi 143

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APRIL, 1908.

ON A FORM OF CHRONIC SUPERFICIAL DERMATITIS IN CIRCUMSCRIBED PATCHES WITH SYMMETRICAL DISTRIBUTION OCCURRING IN CHILDREN.

By H. G. ADAMSON, M.D.Lond., M.R.C.P.,

Physician to the Skin-Department at Paddington Green Children's Hospital; Chief Assistant in the Skin-Department at St. Bartholomew's Hospital.

1.

The object of this paper is to call attention to a benign but very intractable eruption of not very rare occurrence, at any rate in children, which is characterised by sharply circumscribed patches of a superficial dermatitis, having a more or less symmetrical distribution upon the face, trunk, and limbs.

The eruption is, without doubt, already familiar to dermatologists as a form of "chronic eczema"; and it would be called, usually, "Eczema circumscriptum," "Eczema seborrhoicum areatum," "chronic dry eczema," "discoid eczema," or by some similar name indicating a supposed resemblance to eczema and the chronic nature or the circumscribed form of its lesions.

But such terms are elastic and include eruptions of widely different nature: in some instances veritable chronic eczemas; in others, almost certainly forms of local coccic infection, as shown by the history of their origin, and spread from a local focus of suppuration; while other cases, such as those I am about to describe, are clearly not eczemas, nor can they be so readily regarded as originating from local microbic infection.

Description of the eruption and its clinical course.—Although there is no reason to suppose that this affection may not originate in adults, or be continued from childhood into adult life,* I shall here limit myself to the consideration of the eruption as I have met with it in children, my remarks being based upon the observation of five cases, which have been under my care for periods varying from six months to four or five years.

The patches are seen upon the limbs and face, and, less often, upon the trunk. They usually have a remarkably symmetrical distribution, the most typical arrangement being: a patch upon each cheek, one or two patches upon each upper arm, one or two upon each forearm, and similarly one or two upon each thigh and leg; and sometimes there may be one or more upon either side of the trunk (see diagrams, Fig. 4). The patches vary in size from an inch to two or three inches in diameter; they are oval or circular, or they form irregular patterns by coalescence. They have sharply-defined margins, are red in colour with a shade of brown, and they have a dry and rough appearance due to the presence of tiny adherent scales and crusts. Sometimes they appear to be studded with pin-head-sized papules. But on closer inspection, the structures which look like minute papules are found to be simply little masses of dried secretion

* Cases in adults have been exhibited from time to time at the meetings of the London Dermatological Societies which were possibly of the same nature as the affection I am here considering. They presented chronic patches of dermatitis, generally symmetrically arranged, and very resistant to treatment. Although I have seen these cases I have had no opportunity of comparing them closely with my own and I am unable to state positively that they are of the same nature; but I quote them for convenience of reference. A case of *Eczema seborrhoicum areatum*, Liddell, *Brit. Journ. Derm.*, vol. xiv, 1902, p. 466; a case of *circumscribed eczema*, Graham Little, *ibid.*, vol. xv, 1903, p. 401; *circumscribed patches of dermatitis*, Dore, *ibid.*, vol. xv, 1903, p. 407. (This case was regarded by Dr. Radcliffe-Crocker as *Eczema circumscriptum*, by Dr. A. Whitfield as *discoid eczema*); *circumscribed eruption* on the arms and thighs, Mackey, *ibid.*, vol. xv, 1903, p. 410. All of these cases were in adults. The following, the description of which reads like my own case, was in a child—*chronic dermatitis*, G. Little, *ibid.*, vol. xviii, 1906, p. 185.

FIG. 1.—Photograph of Case 5 showing distribution of patches upon the arms. In this case the patches have been under treatment, but the pseudo-papules or crusts which make up the patches are just beginning to make their reappearance.

Fig. 1

To illustrate Dr. H. G. Adamson's Article on Chronic Superficial Dermatitis in Circumscribed Patches

adherent in limpet-shell-like fashion, and on detaching them a minute moist area is exposed.

There is little or no itching, but the patches get red and burning at times, *e.g.* after washing or exposure. They may sometimes become scabbed or crusted, either from scratching or from neglect of local attention, or, perhaps, as a result of lowering of the general state of health. The children affected are usually not robust, although no evidence of visceral disease, tuberculous or otherwise, is obtained. They are often thin and languid and complain of headaches.

A remarkable feature of this eruption is its *extreme chronicity and*

FIG. 2.—A section under a low power from the arm in Case 1. There is a certain amount of œdema, of prickle-cell layer, and of acanthosis, and a moderate cell-infiltration, mainly around the vessels, in the papillary and subpapillary layers of the corium. The chief feature is the formation of minute scale crusts or vesicles in the horny layer (*a* and *b*).

resistance to treatment. The eruption may continue for many years, varying in intensity, but always affecting the same areas. At one time the eruption may appear almost gone (generally as the result of vigorous and persistent treatment); but soon it presents again the features which I have described, the patches first getting pinkish, then showing the minute pseudo-papules or crusts, then becoming generally scaly; or if neglected, or if the child gets into bad health, showing impetiginous crusts.

Other points, to which I shall refer again presently, are the frequent association with these lesions of chronic rhinitis with nasal crusting, or of chronic otorrhœa, and of Pityriasis alba of the face.

Histology of a lesion from one case.—A small portion of the margin

of a patch on the forearm of Case 1 was excised and prepared for examination.

Under the microscope there was seen: (1) *in the corium,* a slight cellular infiltration mainly around the vessels of the papillary layer; (2) *in the epidermis,* some widening of the prickle-cell layer, with moderate œdema of the prickle-cells. In the horny layer there were at intervals rounded elevations, which were made up of flattened nucleated horny cells in laminæ, with, between the laminæ, blocks of serum; *i.e.* minute superficial vesicles.

Fig. 3.—The lesion at *a* in Fig. 2 under a higher power. It consists of (*a*) blocks of serum between (*b*) nucleated imperfectly cornified horn-cells, forming a scale-crust or superficial vesicle in the horny layer, which recalls the very early lesion of Impetigo contagiosa of Tilbury Fox.

To sum up, there was: slight cellular infiltration in the corium; some slight *acanthosis* with œdema; *parakeratosis,* with sufficient serous exudation to produce here and there minute vesicles or crusts in the horny layer (see Figs. 2 and 3).

Bacteriological examination of the lesions.—Bacteriological examination of the lesions in three of the cases yielded only negative results.*

* (1) The lesions were washed with soap and water and afterwards with alcohol.

Writer's views as to the nature of the eruption.—From clinical evidence I have for long regarded this eruption as probably of local microbic origin, and possibly related to Impetigo contagiosa, in fact as a very chronic form of impetigo. Although my views have not received support from bacteriological examinations, I shall here give my reasons for holding this opinion :

(1) There is generally a history either that the earliest patch began around the ear, which was discharging at the time (Case 1), or else upon a limb around the seat of a crusted wound which had for a long time refused to heal (Cases 2, 4, 5), or the eruption appeared to be a sequel to an impetiginous condition of the scalp (Case 2), or there was a chronic rhinitis with discharge and crusting in the nostril (Case 3). In all cases there is evidence that the eruption began in the first instance in the neighbourhood of an infected wound or of a pus-discharging orifice.

(2) In the course of the examination of a large number of children in hospital practice, I have constantly met with circumscribed patches of a chronic superficial dermatitis, which, individually, as regards their clinical appearance, have been indistinguishable from the patches which I have already described: they have differed only in that they were fewer in number and not arranged with symmetry, and in that they were somewhat less resistant to treatment. Such patches are seen around the ear, upon the cheeks and neck, around the orbit over the forehead and temple and cheek; or as isolated patches on a limb or on the trunk. These patches have

Scales and crusts were then gently scraped away with a sterilised knife, so that minute, slightly moist areas were exposed. From the moist areas inoculations were made on solid media, and in pipettes containing broth. In no case did any micro-organisms develop.

(2) Lesions were cleaned with soap and water, and alcohol, and scales and crusts planted upon solid media, and also put into broth tubes. In these experiments *Staphylococcus epidermidis albus* was almost invariably grown, sometimes with other organisms of a non-pathogenic nature.

(3) Microscopical examination of sections of the lesions for organisms showed only a few cocci here and there in the horny layers and in the crusts.

The difficulties of bacteriological investigation in lesions of this sort are well known, and the finding of an organism so commonly present on the skin as the *Staphylococcus epidermidis albus* is not to be regarded as a proof of its presence as a causative agent. Nor is the failure to find other organisms in these lesions after removing scales and disinfecting a proof of their absence. In future it would be better to inoculate with a small portion of the lesion excised.

obviously arisen in association with some focus of coccic infection, either an impetigo upon the face, a phlyctennlar whitlow on the finger, an otorrhœa, a nasal discharge, or a purulent conjunctivitis. At first the patches are crusted or raw and discharging; gradually they become dry and scaly, forming eventually red, dry, rough, scaly circumscribed areas, which may persist as such for months or for years unless treated vigorously with strong antiseptic applications.

I do not insist that these more localised patches (which are almost certainly of coccic origin), are identical with the more widely distributed lesions of the cases I have described; but clinically they are indistinguishable, and it seems to me possible that they constitute the same affection, although in an earlier stage and before the infection has extended. In some cases I have actually seen some extension occur while the patient was under treatment, but where, owing to irregular attendance, the treatment was not carried out thoroughly. The sequence of events in such cases has been somewhat as follows: Otorrhœa; a large raw weeping area around the ear; the area drying and becoming red, rough, and scaly; the appearance of a similar red scaly patch upon the opposite cheek and in front of the ear and of circumscribed scaly patches upon the limbs. These cases, however, have been all eventually cured by active local treatment, and the patches have not returned, possibly, I think, because the treatment was carried out at a comparatively early stage.

(3) There is a close resemblance between the multiple chronic patches of dermatitis and Pityriasis alba vel simplex ("datre volante"), an affection which is regarded by some observers as of microbic origin (Impetigo furfureuse of Sabouraud), which is often associated with impetiginous crusting in the nostril, or with fissures below the ear, and which is also most obstinate to treatment. Pityriasis alba of the face is, indeed, frequently associated with the chronic circumscribed body patches, but it is such an exceedingly prevalent affection that I lay less stress upon the fact of this association than upon the resemblance in the clinical features.

In spite, however, of the clinical evidence in support of my view that this chronic superficial dermatitis is of microbic origin and of the nature of a chronic impetigo, I am obliged to admit that the evidence is by no means conclusive, and that it lacks bacteriological proof.

(4) The microscopical examination of the lesions at first seemed to

me to confirm my opinion that they were of impetiginous nature; the minute vesicle, formed, not deeply in the prickle-celled layers as in eczema, but superficially in the horny layer, bore a close resemblance, I thought, to the vesicle of streptococcic impetigo. But this view was not supported by the finding of streptococci in the lesions.

Treatment.—At first, for the treatment of these cases I was accustomed to use a 10 per cent. white precipitate ointment, or a mild sulphur ointment, and although there was temporary improvement in some, in others there was little or no result. I then used a stronger application of salicylic acid, resorcin and sulphur, with somewhat better results, but never with complete cure of the patches. Latterly I have employed an ointment of chrysarobin, and by its use I have found that the patches rapidly disappear; although, after the application has been discontinued for a time the patches return, sometimes only after weeks or months of apparent cure. The chronic rhinitis present in several of the cases has also been treated, but in no instance with complete cure, some discharge and crusting in the nostril reappearing from time to time. The irregular attendance of patients perhaps to a large extent explains these imperfect results. The patients have not continued the treatment until the last traces of the eruption have gone, but they have ceased to attend so soon as the lesions had apparently disappeared.

II.—Other Chronic Patchy Eruptions from which this Affection must be Distinguished.

Eczema.—In children, as in adults, one meets with a type of eczema which has been called "patchy eczema" or "patchy follicular eczema," in which there occur upon the limbs, and especially upon the forearms and legs, isolated and more or less circumscribed patches of vesicular eczema. These patches present all the characteristic features of eczema, viz., redness, swelling, heat, and a surface either studded with minute vesicles or crusts, or weeping and bearing larger crusts. They give rise to intense itching, and they are liable to sudden exacerbations as the result of local irritation. It is true that these patches of eczema may last for years, generally with periods of calm, when they become dry, rough, or scaly patches, closely resembling those of the affection I have described. But they are distinguished by their

resentment of vigorous local treatment, and by the tendency of the eczema to spread beyond the patches (to other parts) during an exacerbation. On the other hand, the patches of chronic dermatitis do not itch, and, although they may at times become crusted with impetigo-like crusts, they do not at any time present the inflammatory œdema with miliary vesiculation of an acute eczema.

Eczema seborrhoicum.—The eruption under consideration would no doubt by some be regarded as a form of seborrhoic eczema. But it appears to me to differ from the type of case that one usually regards as seborrhoic eczema (or seborrhoic dermatitis) in that the patches are drier (the scales less greasy) and very resistant to treatment. Eczema seborrhoicum is more acute in its onset and in its course; it is associated with "seborrhœa sicca" of the scalp (which the other eruption is not); the lesions are evidently made up of papular elements in relation with the pilo-sebaceous follicles; the scales are yellow and moist or greasy in appearance, and the eruption is readily removed by the application of mild anti-parasitic drugs, particularly by mild sulphur ointments. One is familiar with eruptions having these features occurring in children as circumscribed patches upon the trunk and limbs, or as a more diffuse and generalised eruption, and whether or not one calls them "seborrhoic eczema," they are to be distinguished from the much more chronic and resistant patches of the eruption I have described.

Lichen scrofulosorum.—This eruption differs from the chronic dermatitis in patches in that its lesions are made up distinctly of follicular papules, in the comparative readiness with which it yields to treatment, in its tendency to attack the trunk particularly rather than the limbs and face, and, above all, in its frequent association with tuberculosis and with Acne scrofulosorum. Sometimes, indeed, the patches of chronic superficial dermatitis may closely simulate those of Lichen scrofulosorum, viz., when the lesions have been partially removed by treatment and allowed to progress again; the minute pseudo-papules or crusts may then be easily mistaken for the follicular papules of Lichen scrofulosorum.

Histologically the lesion of Lichen scrofulosorum is altogether different from that of the chronic dermatitis: it is a follicular papule resulting from a cell infiltration of granuloma type, a condition which is absent in the other affection.

Eczema scrofulosorum (of Boeck).—It is possible that the eruption I am now dealing with is the same as that described by Boeck under the term Eczema scrofulosorum, although Pautrier regards the latter as identical with Lichen scrofulosorum. Eczema scrofulosorum is described as being characterised by red or chamois yellow patches, more or less infiltrated, which generally present no weeping, but which are dry and lightly scaly, though they may be in parts weeping and crusted. The lesions occur chiefly on the lower limbs, on the thorax, and on the outer sides of the arms and fore-arms. There is often a condition of Pityriasis capitis. The patches when regressing are said to sometimes present nothing more than small circumpilar papules like those of Lichen scrofulosorum.

But whether Boeck's cases are Lichen scrofulosorum or whether they are identical with those I am describing, I would emphasise the fact that my cases have shown no evidence of tuberculosis;* and for this and other reasons which I have given above I would distinguish them from Lichen scrofulosorum or allied eruptions.

Parapsoriasis (of Brocq).—The eruption of chronic superficial dermatitis in circumscribed patches must be distinguished from the *parapsoriasis en plaques* of Brocq (érythrodermie pityriasique en plaque disseminée).† In parapsoriasis en plaques the patches are smaller, they have no symmetrical distribution, they do not (or very rarely) occur upon the face, and they are seen generally in young adults and not in children. The lesions are almost without infiltration, very little scaly, completely dry, never crusted nor impetiginised. Histologically, too, they differ from the lesions of the chronic patchy dermatitis.

* Recently I have tested two of the cases here recorded with Calmette's serum, with negative results.

† The following is a summary of the affections styled by Brocq "Parapsoriasis." It is only concerning Group III that there could be any question of diagnosis from the affection I am describing.

Les parapsoriasis.

Group I.—Première variété (Très proche du psoriasis), *Parapsoriasis en gouttes* (like Jadassohn's case).

Group II.—Deuxième variété (Intermédiaire au lichen et au psoriasis), *Parapsoriasis lichénoïde* (Parakeratosis variegata, Unna; Lichen variegatus, Crocker).

Group III.—Troisième variété (Tres proches des parakératosis psoriasiformis), *Parapsoriasis en plaques* (Érythrodermies pityriasiquès en plaques disséminées, Brocq; Xantho-erythrodermia perstans, Crocker).

Parakeratosis psoriasiformis (Brocq).—Neither do I think that this eruption belongs to the group of affections which Brocq has recently named Parakeratosis psoriasiformis (*Traité Élémentaire de Dermatologie pratique*, L. Brocq, 1907, vol. ii, p. 371), and formerly styled by him "Seborrhéides psoriasiformes." This group includes a large number of forms of chronic superficial dermatitis,* but none correspond with the widely distributed, multiple, symmetrical patches of the cases I am here describing. The fact that its pathological process is mainly a parakeratosis might put it into this group, but Brocq's clinical forms seem to correspond to such as were formerly called seborrhoic eczemas, and I have already tried to show that my cases are of a different type from the so-called seborrhoic eczema.

Conclusions.

(1) There is an affection of the skin occurring in childhood (and probably also in adult life) which is characterised by a superficial dermatitis in circumscribed areas, forming dry, more or less scaly patches of from half an inch to several inches in diameter (or polycyclical plaques from fusion of several patches), having a roughly symmetrical distribution upon the face and limbs, and sometimes also upon the trunk.

(2) On careful inspection the patches are seen to be made up of elements which appear to be minute papules, but which are actually minute adherent crusts, representing very small dried-up vesicles which have formed in the horny layers of the epidermis. These pseudo-papules may sometimes be masked by scaling, or even by impetiginous crusting.

(3) The eruption is *extremely resistant to treatment*, and may last for years.

(4) It is to be distinguished from patchy Eczema, from the so-called Seborrhoic eczemas, from Lichen scrofulosorum, and from Para-

* *Parakeratosis psoriasiformes* (formerly *Seborrhéides psoriasiformes*).

(*a*) *Formes sèches à elements multiples.*

(*b*) *Formes sèches à plaque unique* ou *à elements rares.*

(*c*) *Formes humides* ou *suinantes* ou *eczematisées* : (1) *Variété des plis*, forme vulgaire (*Eczéma séborrhéique vrai*). (2) *Variété eczématiseé en plaque unique*, ou *en larges éléments rares.* (3) *Variété érythrodermique* (Pityriasis rubra séborrhéique).

(*d*) *Pityriasis psoriasiformes ayant l'aspect de pityriasis rosé de Gibert.*

psoriasis en plaques of Brocq. Histologically it might be classed with Brocq's group of Parakeratosis psoriasiformis, but it does not correspond with any of the clinical varieties of this group.

(5) Clinically, there is evidence suggesting a close relationship with Impetigo contagiosa—that it is, in fact, a very chronic form of impetigo.

(6) Bacteriologically, however, there is absence of proof of such relationship.

III.—Cases.

Case 1 (see diagram, Fig. 4).—Mabel L— first came under observation in March, 1903, when she was ten years of age. An eruption had been present for three months. The case was labelled "? Seborrhoic dermatitis." The eruption persisted in spite of treatment.

In December, 1903, she became an in-patient, and it was then recorded that since infancy she had suffered from discharge from both ears. At about ten years of age she had been troubled with raw weeping patches behind and below the ears. At about this time also a patch "like ringworm" had appeared upon one arm. Other patches had then come upon the other arm and upon the legs. On admission the eruption was remarkably symmetrical in distribution.

On the face there was a band extending around each ear, covering the mastoid area behind the ear, passing below the ear, and on to the cheek in front of the ear up to the level of the eyebrow.

On the arms there were circular patches and larger polycyclical areas upon the extensor surfaces of the upper arms.

On the legs at the front of the thighs on each side there was a single patch, and below the knees over the shins oval patches with their long axis vertically.

On the trunk an irregular plaque made up of coalescing patches around the right nipple. The skin around the left nipple is scarred from an old burn, and there was also a patch here which extended on to the scar.

These patches were in appearance red, rough, and dry, and they were thinly covered with small adherent scales. On close inspection with the lens there were seen apparently small red follicular papules thickly placed over the whole patch, but more careful examination showed that these structures were not papules, and that they were really small adherent crusts, which on removal with forceps showed a moist area beneath. The eruption did not itch, and there were no signs of scratching. It was said to get more red and burning at times, but it never wept nor presented the red swelled appearance of a patch of acute eczema.

Under vigorous treatment in hospital with sulphur and salicylic acid ointment the eruption almost disappeared; but after the patient had been home again for a few weeks the patches began to reappear. As they recurred it was possible to study more closely the primary elements of the patch, and these were noted to be minute superficial vesicles which immediately became pin-head-sized crusts simulating papules, but easily removed with the forceps and showing a tiny moist area beneath. These small pseudo-papules or crusts sprang up close

together all over the whole area previously occupied by the scaly patch. Subsequently the whole patch became more scaly and the individual elements less apparent.

The biopsy, the results of which are described above, was made when the eruption had been allowed to reappear after partial removal by strong applications. These notes were made in January, 1904, and the patient was under treatment on and off for a year or so afterwards, the eruption improving under treatment and relapsing when the patient ceased to attend. During the last eighteen months she was not heard of until written to to come up. She appeared recently with the eruption as bad as ever. She is now fourteen years of age.

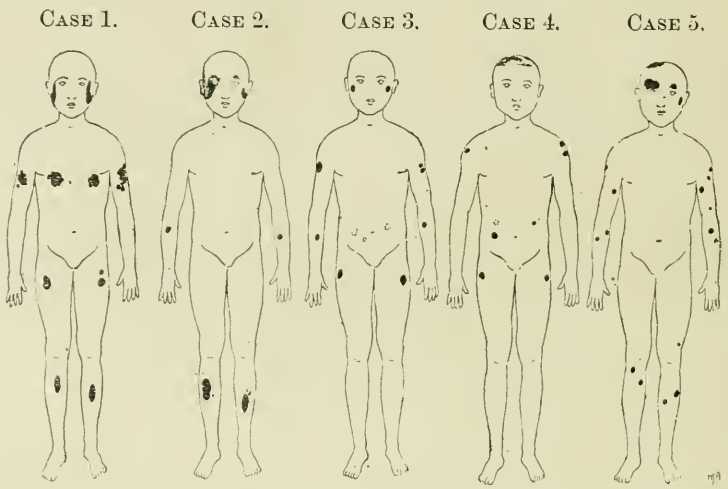

Fig. 4.—Diagrams indicating the distribution of patches in the five cases recorded in this paper. Note the distribution on the cheeks in front of the ears in Cases 1, 2, 3 and 5; on the shoulders and upper arms in Cases 1, 3, 4, and 5; on the fore-arms in Cases 2, 3 and 5; on the thighs in Cases 1, 3 and 4; and on the shins in Cases 1, 2 and 5. The dotted outlines on trunk in Cases 3 and 4 represent patches on the back.

Case 2 (see diagram, Fig. 4).—Ada C— first came to the hospital in September, 1903, when she was four and a half years of age. It was then noted that on the right leg in front and midway between the knee and ankle there was a large, red, slightly infiltrated patch with sharply defined borders, raw and discharging in places, but for the most part covered with thin crusts or scales. This patch had been present about two months. On the scalp there were patches of impetiginous character, some covered with the usual crusts of impetigo, others of more scaly aspect. These had been present about three months. On the face there were rough red scaly patches, here and there a few tiny crusted papules. The diagnosis was made as follows: Impetigo of the scalp, Pityriasis alba on face, chronic dermatitis (impetigo) on leg. Under treatment with white precipitate ointment the lesions got apparently well, and the patient ceased to attend.

Fifteen months later (December, 1904) she again came to the hospital. The mother stated that after the last attendance the face and scalp had been quite

well, but that the patch on the leg had never entirely gone. The eruption had lately returned and it now presented the following appearances:

Upon either cheek, in front of the ear, is an extensive elongated patch of dermatitis embracing the ear with its posterior margin. The patches are red and scaly, with, towards their central parts, a few impetiginous crusts. There are a few scaly macules around the mouth, and there is a small scaly patch upon each eyebrow and upper lid. Just within the right nostril is a crusted excoriation.

On the front of each shin is a large fawn-coloured circumscribed oval patch covered with small adherent scales, and here and there excoriated or crusted; and there are a few outlying smaller scaly macules around these patches.

On each forearm is a circumscribed patch one to one and a half inches in diameter, red, rough-looking, slightly scaly. These patches have only recently appeared.

Under the vigorous application of an ointment of sulphur, resorcin, and salicylic acid these patches gradually became fainter, and after about six months' treatment they were almost well, and the patient disappeared for a time.

In June, 1906, she again came under observation with patches in the situations exactly as before. All of these patches were now dry, red, and covered with fine scales. On close inspection they appeared to be studded with minute papules, which proved, however, to be small adherent crusts.

In May, 1907, this patient was still under treatment. The patches disappear under the application of a chrysarobin ointment, but sooner or later they return. From time to time there is a crusted condition of the margins of the eyelids. The patient is thin and always in poor health, although no definite cause can be discovered.

Tested, in February, 1908, with Calmette's serum, this patient gave no reaction.

Case 3 (see diagram, Fig. 4).—Percy H— is now six years of age, and he has attended the hospital for two years. On his first visit in April, 1905, the following note was made: *The eruption* consists of circumscribed patches of a superficial dermatitis. The patches are distributed with a noticeable symmetry upon the cheeks, arms, and legs. They have been present for several months. The lesions are as follows: A florin-sized patch upon each cheek in front of the ear; an oval patch, one and a half inches by two inches, upon the outer and upper part of the right arm, and two smaller patches in an almost corresponding position on the left arm; a patch upon each forearm; two or three patches over the lower part of the back; and a patch upon the outer and upper part of each thigh. These patches are sharply circumscribed, rough in appearance, red, and covered with fine adherent scales. Close inspection reveals pin-head-sized adherent crusts, which give the appearance of minute spaced papules. The boy is weakly, and pale, and thin, but there is no evidence of tuberculosis. Within the right nostril is a crust, which when removed shows an excoriated area beneath.

Improvement in the general condition and fading of the rash resulted after several months of treatment, and the child was not seen again for nearly a year. He then returned with the condition exactly as before, and he has since been attending, though irregularly, up to the present time. The nose has been

examined by Dr. Peters, who reports that there is a condition of chronic rhinitis, and for this he is now being treated.

Case 4 (see diagram, Fig. 4).—William C— was seen for the first time on February 20th, 1906. He was then five years old, and the eruption had been present for twelve months. It began on the vaccination mark on the left arm (apparently long after this was healed); then it came upon the right arm in a corresponding position, and then upon the thighs.

The notes state that there were two circumscribed, shilling-sized, scaly, or slightly crusted patches upon the scalp. Over the shoulder on either side is a shilling-sized patch, red, rough, and apparently made up of closely-set papules, which, however, with a glass, are seen to be really tiny dried crusts. On the upper part of each thigh and towards the outer side is a similar patch, and there are others upon the abdomen and the back, also arranged with a rough symmetry upon either side. From the left nostril is a thin sero-purulent discharge, and there are crusts within the nostril. A culture from this discharge was purely streptococcic.

During the following few weeks improvement took place under the use of a mild sulphur ointment, but later the patches reappeared. They were again treated and they faded, to reappear once more in the month of March, 1907.

Case 5 (see diagram, Fig. 4).—Winifred G—, aged 8 years. First came to the hospital in April, 1907. The notes state that some months previously there appeared upon the right eyebrow a little sore which healed and broke out again. Gradually it spread until there was a large "mattery" sore over the whole of the right side of the forehead. This sore area had since dried and become a red and scaly patch. Meanwhile other patches had appeared upon the arms and the legs. At the present time the eruption is as follows:

Upon the forehead there is an irregularly circular, red, slightly scaly area, with here and there flat impetiginous crusts. It occupies the right side of the forehead, and extends over the eyebrow and on to the upper eyelid. Upon the left eyebrow and upper lid is a smaller, shilling-sized, dry, red, scaly patch.

Upon the upper arms, on the right side are two patches measuring about 1 inch across—one over the deltoid, and one on the front of the upper arm; on the left side are four patches—two over the deltoid, one in front of the arm, and one nearer the elbow.

Upon the forearms there are two patches upon each side.

Upon the legs, on the right side there are two patches just below the knee; on the left side, one patch upon the thigh and two upon the leg at its middle third in front.

All of these patches are red, dry, and slightly scaly, and on close inspection they show what appear to be pin-head-sized papules regularly spaced, but which proved to be adherent crusts.

The patient appears to be in fairly good health; there is no otorrhœa, and no nasal discharge nor crusting.

This patient has also failed to react to Calmette's tuberculin test (February, 1908).

THE SIXTH INTERNATIONAL DERMATOLOGICAL CONGRESS AT NEW YORK IN SEPTEMBER, 1907.

The Sixth International Congress of Dermatology was held at the Academy of Medicine of New York on September 9th to 14th, 1907, under the Presidency of Dr. James C. White, of Boston. This is the first occasion on which the Congress has been convened on the other side of the Atlantic. Of all the events in the progress of dermatology in recent times, the International Dermatological Congresses are probably the most important. They form the milestones on the way; they are the final courts of appeal in dermatology. Each one in its turn has marked a distinct advance in the subject, and the present Congress is no exception to the rule. It is not so much on account of any sensational discovery having been announced that this Congress will be remembered, but rather that it gave evidence of the steady progress which has been made since the last International Dermatological Congress at Berlin in 1904, and served to indicate the excellent work which is being carried out in dermatology by our colleagues in the west.

The first session of the Congress, as is usual, was devoted to addresses of welcome to the members. Surgeon-General P. M. Rixey, U.S. Navy, representing President Roosevelt, heartily welcomed the visitors, and was followed by Dr. Ira Remsen, President of Johns Hopkins University, Dr. Joseph D. Bryant, President of the American Medical Association, and Dr. J. C. White, President of the Congress. In his address Dr. White gave a short sketch of the advances which had been made in dermatology during the last half century. He referred to the unnecessary division of diseases and the multiplication of titles, which had rather retarded than advanced the subject, as they tended to magnify the significance of slight clinical variations at the expense of broad principles. He considered that well-established landmarks in dermatology should not be changed except for reasons founded on demonstrable differences in anatomy and ætiology. He advocated "the creation of a standing committee of the Congress to consider the subject in a broad way, composed of members from different parts of the world, unprejudiced by past

systems of schools or individuals." He suggested the following questions for consideration and discussion:

(1) What are the influences of race, geographical conditions, climate, national customs, etc., upon the evolution and type of diseases of the skin?

(2) What variations did emigration induce in dermatoses?

(3) What cutaneous affections should national governments regard as infective and seek to control by enforced isolation and similar measures?

(4) How far was it possible and incumbent upon national governments to control the continuance and prevalence of hereditary dermatoses by restriction upon marriage laws?

(5) Should not the influence of such a committee as he proposed be directed to induce governments to aid in the support of researches bearing upon sanitary questions of national importance?

He referred also to the importance of the study of tropical diseases by experienced dermatologists on the spot. Up to the present time the chief difficulty in the advancement of this branch of dermatology has been that the descriptions of many of the rarer forms of tropical dematoses have been made by observers who were not experts in dermatology and had not the opportunity of thoroughly working out the diseases scientifically. To obviate this difficulty he advocated the formation of an international committee, consisting partly of the members of the Congress and partly of well-known authorities on tropical diseases in all parts of the world, to raise the means to carry on and to superintend such investigation.

The official subjects for discussion chosen by the Organisation Committee were:

(1) The ætiological relationship of organisms found in the skin in exanthemata.

(2) Tropical diseases of the skin.

(3) (*a*) The possibility of immunisation against syphilis; (*b*) the present status of our knowledge of the pathology of syphilis.

The first subject resolved itself chiefly into a consideration of the nature of the Cytoryctes variolæ of Guanieri and its ætiological relationship to smallpox. This was introduced by a report by Professor W. T. Councilman, of Boston. He stated that it was believed that the cause of the disease was this parasitic organism, which had its habitat

in the epithelial cells of the specific lesions of the skin, and that the same organism, up to a certain period of development, was found in vaccinia. It was believed that there were probably two cycles of development of the organism: (1) an imperfect cycle common to both vaccinia and smallpox, and (2) a complete cycle representing a further development of the vaccine cycle which was only found in smallpox. The virus of smallpox differed from that of vaccinia in its capacity of transmission without contact. Professor Gary N. Calkins, of New York, also described in detail the life-cycle of the organism. He considered it to be a rhizopod, in which only one phase of the life-history was known, viz. the asexual or vegetative phase.

The subject of tropical diseases of the skin was introduced by Surgeon-General P. M. Rixey with a paper entitled "The Relation of the Navy to the Study of Tropical Diseases." He was followed by Dr. Radcliffe-Crocker. Dr. Stiles, of Washington, referred to the frequency of "ground itch" in the Southern States in connection with "uncinariasis," and demonstrated preparations showing the larval hookworms passing through the skin. Dr. Still contributed a paper on "The Clinical Grouping of Tropical Ulcers of the Philippines." Among the sailors of the naval hospital at Canacas two distinct types of chronic ulcer were observed, the first conforming to Fayrer's description of Delhi boil, the second resembling Jeanselme's tropical phagedæna. Smears from ulcers of the first type showed no protozoa, while those from the second type showed a bacterium. Valuable contributions were also made by Drs. Mink, MacLean, Shattuck, Tanaka, and Aldo Castellani.

The subject of syphilis was introduced by Professor Hoffmann, of Berlin, with a "Report on the Present State of our Knowledge of the Parasitology of Syphilis." He mentioned that the *Spirochæta pallida* discovered by Schaudinn and himself was the cause of syphilis, and bore the same relation to the diagnosis of syphilis as the tubercle bacillus did to tuberculosis. He demonstrated the organism in the living state, as well as in smears and tissues. Other contributions on this subject were made by Professor Gaucher, Drs. Hallopeau and Gastou, and others.

Besides the official themes various other important subjects were discussed. Leprosy was brought forward by Professor Campana, of Rome, in a paper entitled "The Proposals to Diminish the Diffusion

of Lepra, and its Treatment." He was followed by Dr. Brinckerhoff, of Honolulu, Dr. Dyer, of New Orleans, and Dr. Foster, of St. Paul, who all recognised the communicability of the disease and the importance of segregation.

The opsonic method in skin-diseases and the treatment of skin-affections by bacterial vaccines was dealt with in papers by Drs. Arthur Whitfield, E. M. Von Eberts, Schamberg, and Gildersleeve.

Radio-therapy was introduced by Dr. Abbe, of New York, who demonstrated a series of wax casts, showing the results from the use of radium in epithelioma, and who strongly recommended radium as the best means of treating rodent ulcer of the eyelid.

On three of the mornings there were demonstrations of rare cases with a discussion on them. These demonstrations formed one of the most attractive features of the Congress. There was also an exhibition of photographs and drawings, microscopical specimens, wax models, and cultures. A demonstration by Dr. C. T. Dade (New York) on liquid air in the treatment of nævi, rodent ulcer, and Lupus erythematosus, showing cases during and after treatment, was received with much interest and appreciation.

The social aspect of the Congress was by no means neglected, and the proverbial hospitality of our American cousins was everywhere in evidence. What with a reception and a banquet at the Waldorf-Astoria, an excursion up the Hudson and down to Coney Island, and numerous private entertainments, the Sixth International Congress will always be remembered by those who had the good fortune to be present as one of the most pleasant which has yet been held.

At the business meeting, held on September 11th, it was decided that the Seventh International Dermatological Congress should be convened in Rome in 1911, and Professor T. de Amicis, of Naples, was elected President.

ROYAL SOCIETY OF MEDICINE.

DERMATOLOGICAL SECTION.

A Meeting of this Section was held at 20, Hanover Square, on Thursday, March 19th, 1908, Dr. H. Radcliffe-Crocker in the Chair.

The following cases and specimens were shown :

Dr. H. G. Adamson showed (1) a case of *pustular ringworm of the horse* (*"conglomerate folliculitis"*) *in a child*. The patient was a boy, aged 2 years, who presented on the front of the right leg below the knee a circular patch three inches in diameter, red, deeply infiltrated, and studded with pin-head-sized pustules. The appearances had at once suggested ringworm of the horse, though it was unusual to meet with this type of ringworm in a child. The father of the child was a harness-maker, and often received old harness for repairs. Pus from an unbroken pustule showed chains of very large, oval, and rounded spores—quite unlike the segmented mycelial threads of the vesicular "cat-ringworm" of children—and cultures gave the typical plastery-white, rapidly-growing culture of *Tricophyton megalosporon ectothrix du cheval à cultures blanches*. The exhibitor had seen two examples of this type of horse ringworm in ostlers on the arm, and two cases on the beard region, but had not previously met with a case in a child.

(2) Case of *Urticaria pigmentosa*. The patient was a boy, aged $2\frac{1}{2}$ years, with Urticaria pigmentosa of the macular type. The child had been quite healthy until about six months of age. He had then been troubled with itching patches which "looked exactly like insect-bites." They were pink, raised, and with a central darker "spot"; when the pink colour faded there remained a brown patch. The brown patches had persisted, and fresh ones had appeared. Now there were about sixty in all—forty on the front of the body, chiefly on the chest and abdomen, and about twenty on the back. There were a few lesions also on the thighs and legs. Factitious urticaria was well marked. After briskly rubbing the patches for a few minutes they became inflamed and surrounded by a pink, raised, sharply-margined wheal. The patient had been brought to the hospital on account of his restlessness at night, when the lesions became urticarial.

Dr. Savill asked whether calcium chloride had been tried. He had had one or two cases of Urticaria pigmentosa which had been improved by it.

Dr. Adamson replied that he had not had the opportunity of trying it, as the patient had not been under his care more than a week. In four or five other cases he had tried salicin, and it seemed to control the urticaria; he had not tried calcium chloride.

Mr. T. P. Beddoes showed for Dr. Abraham a mouse with *favus*, brought by a patient, a man, aged 43 years, who came two weeks ago with typical parasitic sycosis, which he had had for one month, forming a raised patch on the chin half an inch in diameter with swollen follicles. Immediate examination showed large-spore mycelium in the sheath of the hair.

The patient was in the habit of being shaved by a barber. He stated that one of his three children three months ago had a sore patch on the chin which had been cured by vaseline.

The patient to-day brought his child, whose skin was quite normal, and a dead mouse (the specimen exhibited) caught by patient's wife with her hand four days ago; it lived two days. It showed hard, white, much-raised crusts on the ears and forehead without any characteristic smell. The mycelium under the microscope was indistinguishable from favus.

Dr. Abraham considered that the man had typical *Tinea barbæ* due to a trichophyton, and that the mouse had favus, and that the two were simply a coincidence. To make sure of this further examination with cultures would be made.

Mr. G. W. Dawson showed a young man, aged 22 years, with a *ringed eruption* about 1½ inches in diameter on the middle knuckle of the left hand. The ring consisted of a number of isolated, flat, clearly-defined papules of the same colour as the skin. They were slightly depressed in the centre, were hard, and rose abruptly from the skin. One of them was broken up into five wedge-shaped portions.

The eruption began seven years ago on the apex of the knuckle, and the patient stated that each papule gradually enlarged, broke into several portions, and finally disappeared in four or five months, leaving apparently normal skin. Others then developed outside this area and underwent the same cycle of changes.

Microscopic examination disclosed swelling of the cells of the stratum mucosum, and marked enlargement of the sweat-glands and ducts.

The President said that it was not typical Lichen annularis; there was a Lichen planus look about the present lesions. The first case he published he described as Lichen-planus-like Lupus erythematosus.

Dr. Galloway considered it a case of Lichen annularis, and said that it reminded him of one in a lady who was under observation for several years, in which case the lesions, as they died away, became concave and very flat.

Dr. Graham Little said he thought it was Granuloma annulare. The characteristic points were the hardness and whiteness of the papules, their umbilication, and the fact that they were very chronic and occasionally disappeared. At St. Mary's Hospital he had a man under care for six months with a continuous crop of similar lesions; they were first white and then red. The section shown did not go very deep in the skin, and the sweat-coils were not well seen, so that it was impossible to pronounce an opinion on this feature.

Mr. G. Pernet said he had maintained that Lichen annularis was the same thing as Granuloma annulare. A case which was brought forward by Dr. Crocker he, Mr. Pernet, examined histologically, and satisfied himself on the point.

Dr. T. Colcott Fox showed a case of *bilateral telangiectases* of the trunk with a history of marked epistaxis in childhood and recent rectal hæmorrhage, and submitted the following notes: The patient, Emily B—, aged 23 years, engaged in housework, was sent to me by Dr. John Norton on account of peculiar telangiectases, and was subsequently admitted to the Westminster Hospital under the care of Dr. Hebb, from December 12th to 23rd, 1907, and again from February 18th to March 14th, 1908. I am greatly indebted to Dr. Hebb for allowing me to report the case with the use of the notes.

The *family history* obtained was that the patient's father died, aged 63 years, of "heart failure," and the mother, aged 60, who had bleeding piles, of "dropsy." A brother of the father is said to have died of pulmonary tuberculosis, and also the mother's two sisters. One brother of the patient was killed by lightning, and another suffers from "fits," dating from an injury behind the ear. A living sister has a discharging, non-bleeding "tumour" on the back of her neck, and a brother and sister have consumption. No evidence was forthcoming of hæmophilia, or marked epistaxis.

The *personal history* of the patient discloses an attack of measles in childhood, mumps at twelve years, and "ulcerated throat" of about a week's duration at fifteen years of age. At ten years old she had considerable epistaxis from both nostrils almost every morning for six months, and at fourteen years she noticed some red spots in the left lower axillary region, and later on the left back, right lower axillary region, and lower part of chest. These spots have gradually increased in number and appeared on a wider area. There is some occasional itching. The menses commenced at eighteen years, and are now regular in time, but marked by much pelvic pain a day prior to the commencement of the flow, which is copious, and

makes her feel weak and short of breath, and her hands and feet cold and numb. For the last six months at least, and especially after standing, she has noticed that her hands, especially the left, go cold and blue, with pallor of the finger-tips and nails, and a tight sensation of these parts. She has had some leucorrhœa for a year past. In the summer of 1907, when walking about, her attention was attracted by bleeding from the rectum, lasting about half an an hour, and accompanied by a sensation of swimming in the head and pain in the lower part of the abdomen and bottom of the back. The blood was dark red and in part clotted. Three months later she had a similar attack, and every week has passed a little blood and matter. On December 6th, 1907, she had a marked rectal hæmorrhage of bright blood, continuing for about four hours. The patient has always been constipated, and generally loses a little blood when she goes to stool. On December 27th a passage of about half a pint of dark blood occurred from the rectum in about a quarter of an hour. The next week and the week after there were similar occurrences, and again on February 16th, always whilst walking. She states that recently, after walking about a mile, she loses vigour in her legs, especially the right, and experiences a pain in the region of the right buttock, back, and outside of thigh down the back of the leg to the ankle, and she remembers that last midsummer she slipped and fell on the right hip. The patient does not bleed unduly from cuts, and she is not subject to blood effusions in the skin. She has had teeth extracted from time to time without any unusual hæmorrhage. On two occasions the rough usage of a bath-towel has caused some oozing of blood for a couple of hours from the dilated vessels.

The patient is a well-formed, healthy-looking girl, with slightly cyanotic hands and coloured cheeks, and rather slow pulse (54 per minute). The tongue is slightly coated. Disseminated without special order over the lower two thirds of the trunk, behind and at the sides, with predominance on the left side, there is a fairly copious purple eruption simulating small hæmorrhages into the skin. On close examination these eruptive lesions are seen to be dilated capillary blood-vessels, punctate at first appearance and gradually conglomerating to form slightly raised papule-like spots, about half the size of a split-pea. They do not disappear by pressure. An isolated spot is situated on the skin outside the right eye. It is to be noted

also that the patient has several soft moles on the face and limbs. She complains of some tenderness down the whole length of the right sciatic nerve, and extending down the back of the leg below the knee to the ankle. The knee-jerks are equal, and the plantar reflexes almost absent.

Whilst under observation in the hospital there was no febrile disturbance, and nothing wrong could be detected in the various viscera, including the kidneys. Mr. Hartridge reported that the eyes were normal, and Mr. de Santi examined the nose and throat and failed to find any indication of enlarged blood-vessels, only some adhesion between the inferior turbinate and septum nasi. Mr. Carling made, under anæsthesia, an examination with the sigmoidoscope of the lower bowel for about twelve inches, and found the mucous membrane normal. Two examinations of the blood were carried out. On December 13th, 1907, the report was:

Proportion of serum to corpuscles obtained by centrifuging	2 : 3
Hæmoglobin	85 per cent.
Red blood-corpuscles	4,600,000
White blood-corpuscles	5700

Polymorphs 49 per cent. (fine granules 48, coarse 1). Monomorphs 51 per cent. (large 8, transitional 23, small 20).

Coagulation time 3 minutes and 50 seconds, and the same on December 19th.

On March 10th, 1908, the red corpuscles were 5,500,000, the hæmoglobin 92 per cent., and the proportion of serum to corpuscles 1 : 1.

A biopsy was made of a little cluster of the eruption on the back, and the sections display the dilatation of blood-capillaries without any other changes (sections demonstrated). I am greatly indebted to Dr. H. G. Adamson for the drawing of the section.

The PRESIDENT said he had seen warts develop from such conditions, but not true angioma. He understood that there were no lymphatic vesicles.

Dr. COLCOTT FOX, in reply, said he would discuss the subject in a paper in the *Journal of Dermatology*. Politzer, in his *International Atlas of Rare Skin-Diseases*, reported a remarkable case of the kind all over the body, and called it nævus, as it occurred in very early life. The present patient had a number of moles. It began at fourteen years of age, and she was now twenty-three.

Dr. WILFRID FOX showed *a case for diagnosis* of a girl, aged 18

years, who was suffering from two shallow ulcers; one, situated on the chest just to the left of the sternum, had been present for a month; the other, on the outer side of the left knee, appeared only a fortnight ago. Both ulcers were similar in appearance, measuring about 2 inches in diameter, the surface being covered by a dry, semi-transparent parchment-like substance, through which the superficial veins could be seen. A year and a half previously she had cut her hand with a kitchen knife, and the wound had become septic, and only recently healed.

The exhibitor said he had questioned the patient with regard to the artificial production of the ulcers, but had failed to get any confession. She was a very quiet, sensible girl, and not in the least hysterical, and answered questions readily.

The general opinion of the members was, however, that the lesions had been caused by artificial means.

The PRESIDENT said he thought all would agree as to the factitious nature of the lesions, which were on the left side, especially taken in conjunction with the general aspect of the lady. The question was as to the agent employed; unless the lesions were seen fresh it was difficult to determine that. Acid, vinegar, or mustard might be used. He was once called to a provincial town to make a diagnosis in such a case, and suggested toilet vinegar as the agent. It turned out to be a mixture of toilet vinegar and Jeyes' fluid. The same patient used to have morphia suppositories and take them by the mouth.

Dr. PRINGLE said it was surprising what could be done by merely wetting the finger and rubbing it on the skin. He had a patient in hospital for more than a month, and she did it at night, although there was a night-nurse watching her.

Dr. WHITFIELD suggested that either hydrochloric or acetic acid was the probable cause.

Dr. GALLOWAY, in association with Dr. COHEN, brought forward a case of *acute scarlatiniform eruption following the administration of small doses of quinine*. The patient was a man, aged about 27 years, of Jewish race, pallid in complexion, and unduly stout for his years. He came of a family in which there was a marked history of glycosuria. In his own case, however, glucose had not been identified in the urine, though marked phosphaturia had been observed. He suffered from a tendency to seborrhoic troubles, with slight scaly dermatitis of the scalp, which had been eczematous on two occasions, two and three years ago.

Twelve months ago, feeling a little run down in health, he had taken half an ounce of the proprietary medicine known as "Phosferine." Within two hours he suffered from symptoms of faintness, with a sensation of choking, feverishness, followed by a violent scarlet blush over the whole body, including the face and extremities. The most severe symptoms began to subside in the course of a day or two, but was followed by well-marked desquamation, which lasted for some time. A fortnight ago, once more finding it advisable to take a tonic medicine, he visited a house of public entertainment, and obtained a bottle of what was called "Tonic water." This he drank, hoping to benefit. Within two hours he again experienced the exceedingly uncomfortable and distressing symptoms with which he had become familiar twelve months previously after the dose of Phosferine.

The desquamation had not completely ceased when he consulted Dr. Cohen on March 14th, complaining of neuralgia affecting the right side of the face. There were present one or two carious teeth, and until these were properly attended to by the dentist Dr. Cohen prescribed for him a medicine containing one grain of quinine to the dose. He took a dose of this medicine at 3 o'clock on Saturday afternoon. At 6 o'clock the symptoms now familiar to him were fully developed. The temperature was 102° F. He experienced shivering, marked nervous depression; the tongue became very furred; he had "foaming at the mouth," the fauces were swollen, there was much difficulty in swallowing, and the patient not only felt seriously ill, but had all the aspects of a serious and acute disease.

On Wednesday, March 18th, he was brought to see Dr. Galloway in consultation by Dr. Cohen, and on March 19th was presented to the Royal Society of Medicine. The patient was now much more comfortable, the acuter symptoms of the attack having to a great extent disappeared. He still presented over large areas of the body, especially the lower part of the abdomen, the inner side of the thighs, the inner surfaces of the arms, a bright scarlet eruption, now becoming patchy. The whole body, during the acute attack of the previous Saturday and Sunday, had been covered with this acute erythema. Over considerable areas a large quantity of superficial desquamation of epithelium could be observed; the face was as if powdered, owing to this desquamation, and a good deal of scaliness

of the scalp existed, complicated, however, by the previously existing seborrhoic pityriasis.

Dr. Galloway drew the attention of the Society to the fact that Phosferine contained the phosphate of quinine, and that the bitter tonic water which was now frequently sold as a form of aërated beverage also contained quinine in small quantities. The key of the problem, however, had been given when Dr. Cohen prescribed one grain of quinine immediately followed by the acute form of quinine erythema which they now witnessed. Dr. Galloway remarked upon the comparative rarity of the scarlatiniform type of quinine eruption. Its features, however, were of so striking a character and the illness which they provoked was so severe that its existence was well recognised. Numerous cases were on record, and he referred especially to the case described by Dr. H. W. Stelwagon (*Journal of Cutaneous and Genito-Urinary Diseases*, 1902, p. 13). Dr. Stelwagon's unhappy patient had been reduced to such a condition by repeated attacks of the scarlatiniform quinine eruption, that he went about in fear and trembling lest he should inadvertently take a small dose of quinine, or have it prescribed to him in some form by his physician. Dr. Stelwagon refers to eight or ten outbreaks; they may have been more numerous in the history of this unusually susceptible individual. The case brought before them was another instance of this susceptibility to quinine, and served to emphasise the serious character of the attack.

Dr. Dore drew attention to the fact that in all probability some of the acute scarlatiniform eruptions described during attacks of influenza and from unknown causes, might very well be the result of the administration of quinine in the case of individuals with this peculiar idiosyncrasy.

Dr. Willmott Evans said that at the Dermatological Society of London he showed a case of recurrent bullous eruption. The patient took quinine for a time and then burst out into an eruption. She was now well.

The President said the ætiology of the condition was an interesting matter. Very often in such cases there was no history forthcoming. In some cases there were obviously toxic intestinal conditions. In all the cases the patients seemed to become increasingly susceptible to the drug.

Mr. Kettle, introduced by Dr. Graham Little, showed (1) *sections* of a hard Hunterian chancre, stained by Levaditi's method for *Spirochæta pallida*, and showing that organism with unusual clearness and in great abundance; (2) *film-preparation*, made from the unrup-

tured vesicle of a bullous congenital syphilide, and stained with Giemsa's stain. The spirochætæ in the latter preparation were quite distinctly shown, but less perfectly than in the former case.

Dr. Graham Little showed a case of *Bromide eruption* in a female infant, breast-fed, aged 9 months, who had been under the care of Dr. Edgecumbe Burrows, of Manor Park, Essex; no bromide had been given by this gentleman to the infant, who had had a little bronchitis, and had, according to the mother, been taking a mixture containing paregoric and squills. But the mother was a chronic epileptic, and since September, 1905, had, of her own accord, been thrice daily taking a mixture composed as follows:

Pot. brom.	℥iss
Sp. amm. arom. . . .	ʒiv
Aquæ ad. . . .	℥xvj

℥ss. *ter die.*

The eruption had appeared in the child three months ago, apparently on the scalp first. When shown the following was the distribution and character of the rash:

The eruption was most severe and extensive on the right leg, the skin of the leg being almost obscured by the eruption, which consisted of very large framboesioid tumours, surrounded by a red areola; thus there was a patch 2½ in. × 2 in., with a pearly nodular aspect and raised ¼ inch from the general level of the skin, on the outer surface of the leg; another slightly smaller patch, but similar, on the knee; another large fungating patch over the calf; another on the ankle; another on the middle of the front of the leg; and several smaller patches dotted between these. On the right thigh there were two or three smaller patches, and some nodules in an early stage, which showed the characteristic appearance of bromide eruption—the nodules being dotted over with minute, deep-seated, follicular pustules. A section from one of these early nodules was obtained, and would be shown at a subsequent meeting of the Section.

There was a single lesion on the left leg, the size of a two-shilling piece, over the tendo Achillis, raised, and consisting of pearly nodules fused together into a plaque; there was a large, fungating, cauliflower-like patch on the left thigh near the vulva, and several smaller patches and nodules on the buttock.

The sites of vaccination on the left arm were covered by raised nodular patches, and there were similar patches on the left shoulder, front of neck, the summit of the right shoulder, the back of the neck, and the occipital region of the scalp. The face was entirely free.

The mother had never had any similar eruption. The child had not had any illness, with the exception of the slight bronchitis mentioned, and was apparently otherwise well. She had been breast-fed since birth.

The exhibitor had seen only two other cases of equal severity, one shown by him at the Dermatological Society of Great Britain and Ireland in 1900, and another which had come to St. Mary's Hospital a year ago. In both these cases quite small doses of bromide had been given directly to the patients, who were in each case infants, and for quite short periods—in the latter case mentioned the dose had been 2½ gr. a day, given for one week previous to the development of the eruption. The exhibitor had never seen anything approximating to this tumour-formation in adults taking large doses of bromides. Yet, in an interesting paper contributed to the *British Medical Journal* (March 14th, 1908) by Dr. A. J. McCallum, that physician's extensive and special experience had convinced him that adults were proportionately much less tolerant than children to the drug, and notwithstanding the large doses habitually employed by him—as much as 320 gr. *per diem* being given to a boy—"bromide rashes had never given him any trouble." It would almost seem as if small doses were more likely to produce eruption than large doses, and much the same conclusion had been adopted by many clinicians in the consideration of the frequency of eruption following the administration of iodides.

Dr. SAVILL said that some years ago he went into the question of the frequency of the eruption in the cases treated at the West End Hospital for Nervous Diseases, where there were a large number of patients always taking bromide. He was able to collect only about eight cases of the framboesial variety in ten years. Sometimes the eruption came on in patients who were taking quite small doses. One of the subjects of it never took more than ten grains three times a day. Nearly all the subjects of the condition were young people under eighteen years of age.

The PRESIDENT said he agreed with what Dr. Savill had said, but nearly all adults who suffered from bromidism had some affection of heart or kidneys, unless, of course, they were taking gigantic doses. He was once asked to see a case at a fever hospital. It had been sent in as a case of smallpox. The medical men

there knew it was not smallpox, but could not say what it was. He recognised it as a bromide eruption, and said it would probably be found that she had cardiac disease, and it proved to be so. She was taking only small doses of the drug. There was in his *Atlas* a case pictured in which the patient only had five grains three times a day for a few days, but she had marked albuminuria. The lesions were aggregations of minute pustules. If pricked very little fluid exuded; they were almost solid.

Dr. Whitfield quoted a case under his observation in which the bromide eruption had appeared in an infant three days after birth, the mother having taken the drug during pregnancy. He could thus confirm the experience noted in the present case, where the child apparently derived the eruption entirely from the mother's milk.

Dr. Radcliffe-Crocker showed a case illustrating *the effect of X-rays on Mycosis fungoides* (with drawing before treatment). He said that the patient's age was 31 years, and that she had a distinct specific history. Eight months after parturition an eruption appeared, which looked like confluent smallpox, the whole skin being covered with pustules, except the hands and feet. This was probably due to the fact that she had been taking iodide of potassium two months, and an improvement occurred soon after stopping the drug; then pustules recurred on the parts previously attacked; and she developed some eczema. In June last year she had an universal eczematous dermatitis, dry and scaly, very much as seen at the meeting. The tumours began in November, 1906, the first round the umbilicus on the right side. A few other cases of the kind had a history of syphilis, but the bulk of them had not. She exhibited a point which Mr. Pernet brought out, that there was great longevity in the parents. He had traced such a history in many cases, but he did not know what its significance was. There was a rather acute dermatitis on the feet, and it was questioned whether that was due to X-rays, but a little further treatment by those rays cleared it off. Eczema yielded to X-rays if they were not applied too strong. Some time ago there was shown a clergyman, the subject of Mycosis fungoides, with a large number of tumours, and they were entirely removed by means of X-rays. Some recurred, the treatment was resumed, and the last news of him was that he had married, so that presumably he was fairly clear of the disease. He did not know of a case of permanent cure.

Dr. Sequeira showed (1) a case of *Lupus, with unusual features,*

suggesting Lupus pernio. The patient, a married woman, aged 41 years, lives in Wales. She has two healthy children, aged respectively 9 and 2½ years. There is no history or evidence of tuberculosis in the patient or her family. One of her brothers has rheumatism.

She enjoyed good health until nine years ago, when, after an attack of influenza, she noticed that there was a difficulty in breathing through one nostril. She was treated without benefit. In the next year (1900) the left nostril had become "blocked," and a swelling appeared about the left wrist. In March of that year an operation was performed upon the nose and some "thickened bone" removed. The patient states that this operation gave her no relief, and it was followed by the spread of the trouble to the other nostril. A month after a red spot appeared at the tip of the nose, close to the site of the operation. The red area steadily increased until the whole of the nose and part of the cheeks and upper lip became affected. At the same time the swelling of the wrist spread to the hand on both sides and ultimately to the fingers.

During the summers of 1906 and 1907 the patient states that she suffered a great deal with swellings of the feet, which disappeared. There is still, however, some swelling of both great toes.

In 1904 she had a rather severe attack of "erysipelas" in the face, and in 1907 there were five attacks of similar character. There had been no erysipelas-like outbreaks on the hands.

The patient shows no signs of visceral disease. The urine, on the occasions on which it has been examined, proved to be free from albumen.

She is a nervous woman, highly excitable, but has fits of great depression, probably induced by the chronicity of her disease and the disfigurement it causes. She is thin, but wiry and active. The nose is swollen and red, and the red areas extend out on to the cheeks and on to the upper lip. The skin of the nose is thickened, and when first seen was covered with large dilated vessels. The left ala nasi is partially destroyed, and the orifice is contracted. This is the site of the operation. Dr. Sequeira has not been able to make out any actual lupoid nodules in the tissue affected, but Sir Malcolm Morris, who had seen her before he did, kindly referred to his notes and told him that he found some distinct nodules. The affected areas on the cheeks are red, raised, and also show dilated vessels. The upper lip

is in the same condition, the redness extending down to the margin of the mucous membrane.

The ears are free from disease. Mr. Hunter Tod has examined the interior of the nose. He remarks on the thickening of the mucosa, but could find no evidence of Lupus vulgaris. The buccal mucosa and larynx are also free from disease.

The remarkable feature of the case is the condition of the hands. Both are enormously swollen, the left a little more than the right. The swelling begins at the wrist and involves both the palmar and dorsal aspects. The skin is purplish in colour, thickened and tough, but there is no pitting on pressure. There is swelling also of the digits, which is more marked at the proximal part and produces a curious tapering appearance. The character of the skin is the same as on the hands. The nails are unaffected. Both great toes present a somewhat similar appearance, but less severe. There is no swelling of the feet. From the hypertrophy of the hands it would appear that not only the skin but the subcutaneous tissue is affected.

The circulation at the periphery is obviously bad, but it is remarkable that the patient describes the trouble as being more acute in the summer.

The facial condition has much improved under treatment. The Finsen light has been applied and gave excellent reactions, which have been followed by a diminution of the colour and swelling. The large dilated vessels have been treated by electrolysis with advantage.

General tonic treatment has also been adopted, and the patient has been taking cod-liver oil and a mixture containing iron and arsenic. No alteration in the condition of the hands has been observed.

Dr. Galloway said he brought to the Dermatological Society of London a somewhat similar case, but affecting the lower extremities. The outstanding feature was the constantly recurring attacks of erythema with solid œdema, passing off from a condition of almost elephantiasis. The case was associated with Graves' disease, though that association was probably accidental. Still, it should be borne in mind as possibly associated with the lymphadenoma. Three weeks ago he had a case affecting the left arm, sent up from Woolwich to the hospital, in which a most careful examination failed to reveal any cause for the lymphatic obstruction, X-rays also being used. Yet there seemed to be elephantiasis of the whole left arm. He believed it to be an infective process, but nothing septic could be detected in the case.

The President said it would be agreed that elephantiasis was a mere

symptom of blocking, the question being what caused the blocking? In the past history of the present case there was recurrent lymphangitis, and possibly there was now a faint degree of it in the hands. He thought there must be some infective process.

Dr. WHITFIELD thought the fact that it was present in the two hands was against the idea of septic lymphatic blocking, as also was the slow growth of the condition. He thought they were somewhat allied to Raynaud's disease. And the Lupus pernio which Dr. Colcott Fox mentioned was much more likely to be associated with Raynaud's disease.

Dr. SAVILL suggested that the condition was allied to erythromelalgia, which Weir-Mitchell described. The condition was transitory at first, but became established later. About five years ago he published in the *Lancet* a case of the kind, in which some toxic state was present.

(2) A case of *chronic X-ray dermatitis of the hands; removal of warts by measured doses of the X-rays.* The patient, an operator in the X-ray department of the London Hospital for the past eight and a half years, has suffered from dermatitis of the hands for six years. During the first four years he assisted in the radiographic work, and used the screen in a large number of cases. He also developed radiographs. For the past four years he has been employed only in X-ray treatment. The X-ray dermatitis has shown the usual exacerbations in the winter months. The nails have suffered severely, and the patient is now on leave recovering from an operation on one of them. The backs of the hands and fingers present numerous telangiectases and atrophy of the skin, and both were studded with numerous dark, dry warts. The left hand was worse than the right. The palmar aspect is unaffected, but on the left there has recently appeared a black spot, not raised, and like a pigmented mole in appearance. Several small black points have appeared on the left upper arm.

The patient was shown for two reasons, the first being that the back of the left hand has been cleared of the warts by means of the X-rays. It is important to realise that the diseased condition is due to long-continued irritation of the skin by short, frequent exposures to the X-rays, such as occur in screen work, and in the old and, as has been now amply demonstrated, most dangerous habit of testing the penetration of the tube by the hand and screen. This kind of irritation is entirely different from the use of the X-rays therapeutically by measured doses. The exhibitor had seen great improvement in the condition of the face of a patient suffering from

Xeroderma pigmentosum, the warty growths being removed by the X-rays, and, recognising that the chronic form of X-ray dermatitis is in many respects similar to Kaposi's disease, it was natural to expect a favourable result in the radio-dermatitis. The warty areas were exposed once only to the X-rays; until the B tint was obtained on the Sabouraud pastille. This dose is equivalent to about 5 Holtzknecht units. A definite, but slight, reaction was noticed at the end of twelve to fourteen days, and the areas are now, five weeks later, quite smooth. They still, of course, show telangiectases and atrophy, with a little pigmentation. The left hand, the worst, has been treated, and the patient was shown at this early date, to demonstrate the contrast between the treated and untreated hands. It is intended at once to treat the right hand. The case is not reported as one of cure of X-ray warts, for the time is far too short to be certain whether the improvement is more than transient. The fact, however, that the warts may at any time become epitheliomatous renders it of the greatest importance to get their removal, if this can be done without risk.

The second point of interest in the case is the presence of the pigmented spot, one centimetre in diameter, on the palmar surface of the left hand. In X-ray workers it is the dorsal aspect of the hands and fingers which suffers, so that it is quite possible that the pigment spot may have developed independently. The fact also that several small pigment spots have appeared on the upper part of the arm, which is always covered and protected from the rays, and where there has never been any dermatitis, favours that view. So far no record has been made of the appearance of such spots in X-ray workers, but there is still so much to be learnt about the remote effect of the rays that the exhibitor deemed it sufficiently important to call attention to the matter. He suggested removal of the pigmented spot on the palm in the interests of the patient.

Sir MALCOLM MORRIS said the dermatitis did not necessarily go as a result of the application of the rays. He had a case in which the warts had gone, but the X-ray dermatitis was still going on. It seemed somewhat risky to treat the dermatitis by the agency which was responsible for the original trouble. And the time was too short to say that it was a case of cause and effect.

The PRESIDENT said there was a striking difference between the area which had been treated by the rays and that which was not. He thought the pigmented spots should be treated.

Dr. Whitfield said that he was told by Mr. Reid, the radiographer at King's College Hospital, that no one got X-ray warts on the hands who did not develop photographic plates. The present patient had stopped developing plates five years ago, but he appeared to have had the warts six years.

Dr. J. M. H. MacLeod (in a communication submitted subsequently) considered that the X-rays themselves were capable of producing the warty growths seen in the patient's hands, and that they were not entirely due to the action of the chemical reagents he had been employing in developing X-ray photographs. It had been asserted that the warty growths were not caused by the X-rays, and only occurred in X-ray photographers, but in opposition to this view he cited a case of extensive X-ray dermatitis with warty growths in a man who made X-ray tubes, and whose hands were frequently exposed to the rays, but who was not in the habit of exposing them to chemical irritants. He considered that the warty growths were as much a feature of chronic X-ray dermatitis as the somewhat similar lesions were a characteristic of Xeroderma pigmentosum. With regard to the melanotic lesions on the left palm and arm, he had never seen such occur before, but thought it possible that they might be connected with the X-ray dermatitis, and in view of the possibility of their being sarcomatous considered that they should be destroyed.

Dr. Pringle said the first case of the kind was shown by him at the Dermatological Society of London, and the patient was a photographer. The idea that the condition of his nails was due to X-rays was not generally accepted, but was attributed to the photography.

EDITORIAL.

SIR MALCOLM MORRIS, K.C.V.O.

On Thursday, March 19th, 1908, at the Imperial Restaurant, London, a complimentary dinner was given to Sir Malcolm Morris by his dermatological colleagues to congratulate him on the honour recently conferred upon him by His Majesty the King. Dr. H. Radcliffe-Crocker, President of the Dermatological Section of the Royal Society of Medicine, was in the chair, and a large number of Sir Malcolm Morris's friends were present, including representatives from the provinces and Ireland.

The event which was the occasion of the dinner forms an epoch in the history of British Dermatology, for, as the Chairman pointed out, it is the first time that a title has been given to a dermatologist in recognition of services rendered in that special branch of medicine, and it is an evidence that Dermatology in this country has gained its proper position as a department of medicine worthy of special study

and practice. On this account Sir Malcolm Morris has the heartiest congratulations of all his dermatological colleagues. It is an honour, not only to the recipient, but to British Dermatology, and everyone interested in the study of cutaneous diseases may be justly proud of it.

In a singularly happy speech the Chairman referred to the important work which Sir Malcolm Morris had done in the advancement of his subject, to his keen interest in the Dermatological Society of London, and to his connection with the 'British Journal of Dermatology,' of which he was the founder and one of the original editors.

Sir Malcolm Morris, in his reply, expressed his appreciation of the compliment which his colleagues had paid him, and referred to the great advances which had been made during recent years in the knowledge and treatment of cutaneous diseases. In the unavoidable absence of Sir Patrick Manson, the health of the Chairman was proposed by Dr. J. Mitchell Bruce, and a tribute was paid to Dr. J. J. Pringle by Dr. T. Colcott Fox for his successful arrangement of the dinner.

CURRENT LITERATURE.

THE HISTOLOGY OF THE DEPRESSED WHITE SPOTS IN UNIVERSAL ERYTHRODERMIAS. Felix Pinkus. (*Derm. Zeitschr.*, November, 1907, p. 669.)

The histological appearances described in this paper are based upon the examination of a portion of skin excised from a case of universal Erythrodermia, which resembled Oestreicher's case. Such an Erythrodermie mycosique never develops Mycosis fungoides tumours; it passes rather into lymphatic leukæmia and forms lymphomata. Death may occur before a tumour develops, and for the formation of tumours in Erythrodermie mycosique changes in the blood amounting to lymphocytosis must take place. The development, therefore, of depressed white spots in this disease cannot be due to the retrogression and disappearance of tumours.

It is, however, very interesting to see how such processes correspond with the histological appearances. The centre of the excised portion of skin showed marked thinning of the epithelium, corresponding to the white spot. Round this atrophic portion the papillæ and hair-follicles assumed a radiating position, their lower ends being, as it were, nearer the centre than their outer extremities. In the area of the white patch there was a superficial, slight circum-vascular infiltration. Round it there was a much more marked inflammation, both in cutis and epidermis. Upon the epidermis was situated a compact horny layer,

the nuclei being, as a rule, stained, corresponding to parakeratosis. The keratohyaline layer was correspondingly thin or absent. Between the parakeratotic layers there was an absence of round-cells and pus-cells, which are so abundant in psoriasis and eczema. A distinct layer of small-celled infiltration was situated close to the epidermis and prolonged into the deeper layers around the vessels. This infiltration was of older standing, as shown by the absence of small round-cells and abundance of protoplasmic larger cells. The blood-vessels round which this infiltration was situated resembled the papillæ in their oblique direction. All these inflammatory appearances were less marked in the centre, where the white spot was situated. The epithelium was thin and contained hardly any mitoses. Sweat-glands and hair-follicles opened without showing any unusual appearances into the thinned rete; the keratohyalin layer was strongly developed and the horny layer contained no nuclei. In the cutis well-marked inflammatory appearances were absent; the circum-vascular infiltration was also less. A certain diminution of the elastic fibres in the upper cutis layer seemed to have occurred.

For the development of the above phenomena there are the following possibilities:

(1) The oblique position of the papillæ might be due to diminution or alteration of tension taking place in a portion of skin when excised.

(2) The white spot might take up more room than was formerly allotted to it, and so push out the surrounding tissues excentrically.

These two possibilities are improbable.

(3) The third and last possibility is that in the cutis an atrophy, a contraction, has taken place. This would account for the apparent contraction of the centre and the thinning of the epithelium, the change having taken place along an axis at right angles to the centre of the white spot. An examination of the drawings accompanying the paper certainly tends to confirm this theory and makes the probability of this explanation greater. J. L. B.

A CASE OF "ACNE NECROTISANS ET EXULCERANS SERPIGINOSA NASI" OF KAPOSI. Poisot. (*Ann. de Derm. et de Syph.*, August—September, 1907, p. 566.)

This type of disease, exceedingly rare as it is, is apt to be mistaken for syphilitic ulceration, and the case here reported was, in fact, so mistaken at the earlier consultation at the Hospital of St. Louis. The disease at this time consisted (1) of small papules, red or violaceous, surrounded by a zone of redness, and in some cases surmounted by a pustule, occupying the lower and outer part of the alæ nasi; and (2) small crateriform ulcerations with deep-scarring serpiginous borders, on the right upper edge of the nose. The nose was generally thickened and hyperæmic, with a tendency to the development of telangiectases. There was no glandular enlargement. No syphilitic history, family or personal, was obtainable. The patient was nevertheless put on anti-syphilitic treatment, which was not followed by amelioration of symptoms, but under local measures (ointment of mercury and sulphur), he rapidly improved. Blasto-mycosis was thought of, but no organisms supporting that diagnosis were found.

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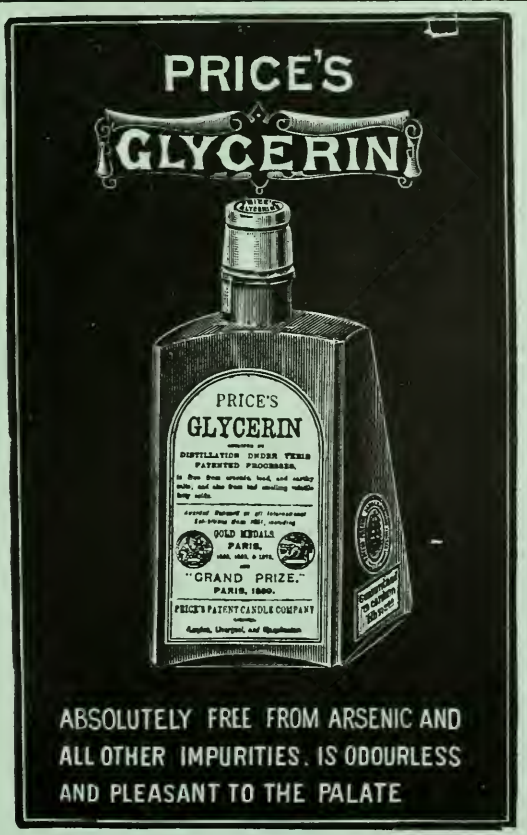

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℞ **Thiol Liquid.** ... ʒiv.
Glycerin ... ... ʒij.

To be used with a camel-hair pencil.

℞ **Thiol Liquid.** .. ʒj.
Vaselin ... ... ʒiij.
Lanolin ... ... ʒvj.

To be used as an ointment.

℞ **Thiol Sicc. Pulv.** ʒj.
Collodii ... ... ʒxix.

To be applied with a camel-hair pencil.

℞ **Thiol Liquid.** ... ʒj.
Pulv. Althææ ... *q. s.*
ut ft. pil. XL.

Sig. Two three times a day.

THIOL LIQUIDUM in ERYSIPELAS.

A medical man writes: "I have found it a specific for Erysipelas. It cuts attacks short within twenty-four hours. One patient never likes to be without it, as she finds when the liquid is painted on it arrests the attack at once."

PASTA THIOL ET ZINCI (Woolley)

Contains 10 % Thiol and 20 % Zinc Oxide.

The *Practitioner* says: "This appears to be an especially good preparation, and has been found to act well in cases of *pruritus of the female genitals*, etc."

THIOL SOAP ("Boval" Brand). 6d. per Tablet.

A Pamphlet, detailing the practical uses of Thiol, together with a history of cases treated with it, will be forwarded free on application.

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